DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 413, 489, and 498

[HCFA-1005-CN4]

RIN 0938-AI56

Medicare Program; Prospective Payment System for Hospital Outpatient Services: Provider-Based Criteria; Delay of Effective Date and Correction

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Notice of delay of effective date and correction.

SUMMARY: In the April 7, 2000 **Federal Register** (65 FR 18434), we published a final rule with comment period entitled, "Prospective Payment System for Hospital Outpatient Services." New §§413.24(d)(6) and 413.65 and revisions to §§489.24, 498.2, and 498.3 established requirements for facilities or organizations seeking provider-based status. This document delays the effective date of these provider-based regulations from October 10, 2000 to January 10, 2001, applicable for provider cost reporting periods beginning on or after January 10, 2001. In this document, we are also making a conforming change in the regulations text at §413.65(i) concerning enforcement.

DATES: Effective Date: The effective date for new §§413.24(d)(6) and 413.65 and revised §§489.24, 498.2, and 498.3 is delayed until January 10, 2001.

Applicability Date: New §§413.24(d)(6) and 413.65 and revised §§489.24, 498.2, and 498.3 are applicable for cost reporting periods beginning on or after January 10, 2001.

FOR FURTHER INFORMATION CONTACT:

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SUPPLEMENTARY INFORMATION:

I. Background

On April 7, 2000, we published in the **Federal Register** (65 FR 18434), a final rule with comment period entitled "Prospective Payment System for Hospital Outpatient Services." Among the regulatory provisions included were new §§413.24(d)(6) and 413.65 and revisions to §§489.24, 498.2, and 498.3. These regulations established requirements for facilities or organizations that seek provider-based status (departments, provider-based entities, satellite facilities, and remote locations of hospitals). The effective date of the provider-based regulations, as stated in the April 2000 rule, is October 10, 2000.

New §413.65(i) states that we will recover any overpayments resulting from inappropriate treatment of a facility or organization as provider-based. However, this provision states that no recovery will be made for any period prior to October 10, 2000, if the management of the facility or organization made a "good faith" effort to operate it as provider-based (as described

in §413.65(i)(3)). The reference to October 10, 2000 was included to limit the "good faith" exception to periods before the effective date of the new requirements.

II. Provisions of this Notice

Based on the following concerns, we have decided to delay the effective date of the provider-based portions of the April 2000 final rule until January 10, 2001, applicable for provider cost reporting periods beginning on or after January 10, 2001. For example, a provider whose cost reporting period begins on April 1 will not be affected by these provider-based regulations until its cost reporting period beginning on April 1, 2001.

To provide for smooth implementation of the provider-based regulations, we must clarify a number of administrative, procedural, and technical issues and provide our regional offices, which are charged with responsibility for making provider-based determinations, and hospitals with further training and guidance. We have completed a variety of training and informational activities, developed responses to "Frequently Asked Questions," and held numerous meetings with individual providers and provider associations in order to communicate our policies and plans for implementing the new regulations. In the course of these activities, the need for additional guidance interpreting the regulations and addressing procedural and administrative concerns has become apparent. Given the time

needed to complete and disseminate this material, we have concluded that implementation of the new provider-based regulations on October 10, 2000 would be imprudent.

A delay in the effective date of the provider-based regulations will allow for dissemination of the additional material described above, and will *give* hospitals and other providers additional time to fully assess the potential impact of both the new hospital outpatient prospective payment system and the new provider-based regulations on their facilities and organizations. A delay in the effective date will also allow the industry more time to prepare to comply with the new regulations, and that in turn will help reduce the number of errors or other problems that might occur as a result of transition to the new rules. The phase-in of implementation over 12-months, rather than a single date, will allow for a more manageable distribution of work for the regional offices, fiscal intermediaries, and hospitals. (As noted earlier, implementation by cost reporting periods means that a provider with a cost reporting period starting after January 10, 2001, would not be affected by the new regulations until the start of its next cost reporting period. Thus, a provider with an April 1 cost period would not be affected until April 1, 2001, a provider with a July 1 cost period would not be affected until July 1, 2001, and so on.) We expect to issue further clarification of administrative, procedural, and technical issues as soon as possible.

To provide for uniform and consistent application of the "good faith" exception to periods before the revised effective date, we are revising §413.65(i)(2) to state that the exception will be available only for main provider cost reporting periods beginning on or after January 10, 2001 or, in the case of a facility or organization paid as a provider-based entity, for that entity's cost reporting periods beginning on or after January 10, 2001.

In October 2000, we plan to host a town hall meeting to discuss specific aspects of the provider-based regulations at our headquarters in Baltimore, Maryland. The subjects of this meeting will be the ways in which a facility or organization can demonstrate that it serves the same patient population as the main provider (§413.65(d)(7)(i)), and the applicability of provisions on management contracts (§413.65(f)) to certain on-campus hospital departments. We will make further details regarding the town hall meeting available on our website, *www.hcfa.gov*.

III. Impact Statement

In the April 2000 final rule, we discussed the impact of the provider-based regulations on providers and beneficiaries. Because we are delaying the implementation of the final rule, the current provider-based criteria, as stated in HCFA program manuals, will remain in effect for an additional period of time.

We believe that any impact on small entities would be positive because the delay in effective date will allow more time for them to come into compliance with the new regulations, and also permit the new regulations to be implemented in a more clear and consistent manner.

Correction of Errors

In FR Doc. 00-8215 of April 7, 2000 (65 FR 18434), make the following correction:

Regulations Text

§413.65 [Corrected]

On page 18540, in column 3, §413.65 (i)(2) is corrected to read as follows:

§413.65 Requirements for a determination that a facility or an organization has provider-based status.

* * * * *

(i) * * *

(2) *Recovery of overpayments*. If HCFA finds that payments for services at the facility or organization have been made as if the facility or organization were provider-based, even though HCFA had not previously determined that the facility or organization qualified for provider-based status, HCFA will recover the difference between the amount of payments that actually were made and the amount of payments that HCFA estimates should have been made in the absence of a determination of

provider-based status. Recovery will not be made for any main provider cost reporting periods beginning before January 10, 2001 or, in the case of a facility or organization paid as a provider-based entity, for that entity's cost reporting periods beginning before January 10, 2001 if, during all of those periods, the management of the facility or organization made a good faith effort to operate it as a provider-based facility or organization, as described in paragraph (h)(3) of this section.

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(Authority: Section 1888(t) of the Social Security Act (42 U.S.C. 1395yy(t))

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare--Hospital Insurance; and Program No. 93.774, Medicare--Supplementary Medical Insurance Program)

Dated: _____

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Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: _____

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Donna E. Shalala,

Secretary.

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